UWHealth SWEDISHAMERICAN
A DIVISION OF UW HEALTH

For Document Integrity Management Office Use Only:
PT EPIC MRN: _____
Date Received: _____
Date Completed: _____
Extension Needed: Yes No
Circle One: UWH SAH

Patient Name: _____
Date of Birth: _____
Address: _____
City, State, Zip Code: _____
Phone Number: (_____) _____-_____

REQUEST FOR AMENDMENT OF THE MEDICAL RECORD

Submit your request to:
UW Health
Attn: Document Integrity Management - Patient Amendment
8501 Excelsior Drive
Madison, WI 53717
Fax: 608-203-1440 – Attn: Patient Amendment

Index to Request for Amendment of Medical Record

Section A: To the Individual- Please read the following and complete the information requested.

You have the right to request that we amend the protected health information in your legal medical record that our business associates or we maintain. I further understand that this document will become a component of my permanent medical record.

We may decline your request if:
- the information is not part of UW Health's/SAH's (please circle) legal medical record;
- we did not create the information;
- we believe the information is complete and accurate;
- the information is contained in psychotherapy notes;
- the information is compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding; or
- the original author of the documentation is no longer practicing at UW Health/SAH (please circle)
- the information is not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. ∫263a).

Please specify which document(s), medical information and/or dates of service you wish to amend (if more space is needed, please attach additional form(s):

_____

_____

Please state the reason(s) and/or attach support for the amendment(s): _____

_____

_____

Section B: To the Individual- Please read the following and follow the instructions regarding the releasing of medical records.

Release of Information – If approved

UW Health patients, if you would like a copy of your amended medical record sent to any previous or new recipients please complete the Release of Information form found at uwhealth.org within the "Obtain My Medical Records" section. Or you can contact the Release of Information Department at (608)263-6030 option 3.

SwedishAmerican patients, if you would like a copy of your amended medical record sent to any previous or new recipients please complete the Release of Information form found at swedishamerican.org within the "Medical Records" section. Or you can contact the Release of Information Department at (779) 696-4540.

Signature of Patient/Representative: _____ Date: ____/____/____
If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Spouse/Domestic Partner of Deceased

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Next of Kin
☐ Health Care Agent ☐ Other: _____
☐ Personal Representative

UWHealth SWEDISHAMERICAN
A DIVISION OF UW HEALTH

Patient Name: _____

Date of Birth: _____

For Document Integrity Management Office Use Only:
PT EPIC MRN: _____
Date Received: _____
Date Completed: _____
Extension Needed: Yes No
Circle One: UWH SAH

REQUEST FOR AMENDMENT OF THE MEDICAL RECORD

Section C: Response to Amendment Request: Provider Section

____ Your request for an amendment has been **APPROVED**; a correction/addendum will be made part of your permanent medical record. A copy of the amended document(s) is attached.

____ Part of your request has been approved, please see below for more details. A copy of the amended document(s) is attached.

____ Your request for an amendment has been **DENIED;** your request has been made a part of your permanent medical record.

Your request was denied for the following reason reason(s):

☐ UW Health/SAH (please circle) did not create the information, please follow up with _____
☐ The information is considered complete and accurate
☐ The information is contained in psychotherapy notes
☐ The information is compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding
☐ The information is not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. ∫263a).
☐ You did not provide enough information to complete the request
☐ The request is regarding billing information and should be directed to: _____
☐ The original author of the documentation is no longer practicing at UW Health/SAH (please circle)
☐ Other: _____

Additional Information:

_____

_____

_____

Provider Signature: _____Title: _____Date: _____ Time:_____

Section D: Patient Options and Contact Information:

If your request is denied:
You may submit a one-page statement of disagreement regarding the denied request. If you do, we will append or link your statement, or an accurate summary, to the medical record(s) you wanted amended for inclusion in future disclosures of those records. We may prepare and send you a rebuttal to your statement of disagreement and, if we do, we will append or link our rebuttal to those same records for inclusion in future disclosures of those records.

Instead of submitting a written statement of disagreement, you may request in writing that your request to amend those records and this denial be appended or linked to those records to be included with future disclosures.

Additional Contact Information:

UW Health patients, if you have questions, wish to discuss the denial or review your options, please contact: Document Integrity Manager (608) 203-4559. If you would like to file a complaint or discuss the quality of your care, please contact Patient Relations at (608)263-8009.

SwedishAmerican patients, should you have any additional questions, concerns, or complaints regarding this matter, please contact the Privacy Office at (779) 696-7225.

You may also file a complaint regarding the denial of this request for amendment with the Secretary, Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601; 800-368-1019; 800-537-7697 (TDD), 202-619-3818 (FAX).

For more information on the amendment process please visit: uwhealth.org and search for “Patient Amendment” in the upper right corner.